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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lena Living Center	1010 South Logan Street Lena, IL 61048

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review the facility failed to investigate an injury of unknown origin as possible abuse for 1 of 3 residents (R1) reviewed for abuse in the sample of 3.The findings include:R1's Face Sheet printed on 2/25/26 showed he had the diagnosis of dementia and right above the elbow arm amputation.On 2/24/26 at 10:45 AM, V3 (R1's Daughter In-Law) said R1 had a black eye and the facility was unable to explain how R1 got the black eye.R1's Progress Note dated 9/18/25 at 2:08 PM, entered by V10 (Licensed Practical Nurse) showed R1 had bruising to the corner of his left eye that was dark purple in color and approximately 3 centimeters (CM) x 0.5 CM. The same note showed R1 was alert and oriented times one and was unable to explain how the bruising occurred.R1's Progress Note dated 9/18/25 at 11:50 PM showed R1 also had bruising to his left upper arm measuring 10 CM x 5 CM that was light purple/blue in color. The note indicated R1 was unable to explain how the bruising occurred.On 2/25/26 at 12:06 PM, V10 said she was taking care of R1 when the bruising was found. V10 said R1 was confused and could not explain how he got the bruising. V10 added that she was not sure how R1 sustained the bruising, and no one witnessed how R1 got the bruising. V10 said she treated the bruising like an injury of unknown origin and possible abuse. V10 said she notified V2 (Director of Nursing) of the bruising and filled out a Risk Management form. An Incident Form (undated) entered by V10 showed R1 had bruising to the left eye about 3 CM x 0.5 CM that was dark purple and bruising to the left upper arm that was 10 CM x 5 CM. The same form showed R1 was unable to explain the bruising. The form showed R1 was alert to place only, confused, and with impaired memory. According to the form, V2 was notified of the bruising on 9/18/25 at 1:56 PM. On 2/25/26 at 12:38 PM, V2, Director of Nursing, DON, said a Risk Management form was filled out regarding R1's bruising. V2 said R1's bruising was explainable therefore not treated as abuse. V2 added that R1 had a behavior of going to the end of the hallway and grabbing the door handle. V2 said it was plausible that the resident sustained the bruise while trying to open the door. V2 clarified that no one saw R1 swinging or forcefully pulling on a door handle, grab bar, or wheelchair component that caused the bruising. R1's Risk Management/Incident Report dated 9/18/25 signed by V2 showed R1 was noted with bruising to the corner of the left eye in an area accessible by the resident's functional left arm. Based on behavioral observations it is plausible that the resident sustained the bruise while swinging or forcefully pulling the door handle, grab bar, or wheelchair component. No signs of staff-to-resident or resident-to-resident altercation noted. Skin is otherwise intact with no additional injuries or abnormalities observed. The resident is a poor historian and unable to recall or report the cause of the bruise and there were no witnesses to the injury. There were no prior or current safety alerts specific to this area.On 2/25/26 at 1:20 PM, V2 Director of Nursing, DON, said there was no behavior noted that corresponded with the behaviors mentioned in the Risk Management/Incident Report.On 2/25/26 at 1:25 PM, V11 (Social Service) said her office was next to the door R1 would try to open. V11 said R1 would hold onto the door handle and at times flail his arms when staff tried to remove his hands from the door handle. V11 said she never witnessed R1 (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hit himself. On 2/26/26 at 11:54 PM, V1 (Administrator) said if a resident had bruising to the corner of their eye and the resident could not explain it and there were no witnesses to the injury an injury of unknown origin abuse investigation should be done. V1 said there was no abuse investigation for R1's bruising. The facility's Abuse policy dated 2/17/20 showed the facility must report any suspicious injuries of unknown sources. Injury of unknown origins were defined as an injury where the source of the injury was not observed, and the resident could not explain the injury. Also, that the injury was suspicious because of the extent of the injury or location of the injury (e.g. the injury is located in an area not generally vulnerable to trauma). An example of suspicious injury of unknown origin is a resident who is unable to communicate has a black eye and no one witnessed the source of the injury. The same document showed the administration will conduct an investigation for suspected abuse.